MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY

DURABLE MEDICAL EQUIPMENT AND SUPPLIES (Rev., Jul 99)

PRESSURE REDUCING SURFACES

SECTION A

PATIENT NAME, ADDRESS, TELEPHONE NUMBER, DATE OF BIRTH	PHYSICIAN NAME, ADDRESS, TELEPHONE NUMBER
MEDICAID I.D. NUMBER:	MEDICAID PROVIDER NUMBER:

RESIDENCE: (CIRCLE ONE) Home, Nursing Home, Hospital Rehab Unit Group Home Other:_____

DIAGNOSIS:

(List the stage, location, size, depth, type of drainage for all pressure ulcers)

PROGNOSIS:

TREATMENT PLAN:

PREVIOUS TREATMENT PLAN:

DATE OF LAST EVALUATION BY PHYSICIAN:	PHYSICIANS NAME:

SECTION B

1. Can the patient reposition themselves: Y / N
2. Does patient have coexisting pulmonary disease: Y / N
3. Does patient have a compromised circulation status: Y / N
4. Does patient have fecal or urinary incontinence: Y / N
5. Is patient bedridden: (If yes, how many hours) Y / N
6. Does patient have a nutritional plan: Y / N

7. Narrative description of **ALL** items, accessories, sizes and options, etc., to included model numbers in this section: (If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document).

Y / N ADDITIONAL ATTACHMENTS ARE INCLUDED

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE

MONTANA
Department of Public Health & Human Services